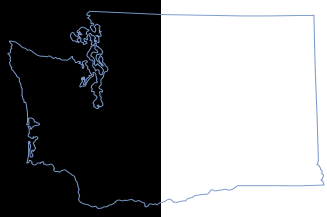


Financing Public Health: Investment that Works for Better Health Solutions

Public health protection is an essential government function, like police or fire protection. Yet financing of the public health system is perched on the brink of crisis, reflecting the tough issues that plague other aspects of state and local government.

The financing picture for public health is complex. Different agencies, programs, and revenue sources are involved at local, state, and federal levels. All of them work on different funding cycles. The complexity makes it difficult to sort out problems and propose solutions. The PHIP Finance Committee has studied four key problem areas:

Historical, persistent underfunding

The National Conference of State Legislatures describes state public health budgets as "minuscule" compared with government spending for individual health care. They attribute this in part to the fact that health care spending is almost exclusively linked to entitlements, while public health spending is not. Without dedicated resources, public health is vulnerable in every budget cycle.

When the 1994 and 1996 PHIPs committed Washington State to a goal of "stable and sufficient" funding for public health, it was with the understanding that the current system wasn't working. The Legislature directed local and state health officials to write standards for public health and determine the costs of adequate services. The reports concluded that the system was affected by very serious underfunding. This was confirmed by the Public Health Finance Committee's activities during the past few years. Its analysis suggests that today's public health system has only about a third of the resources it needs to carry out basic public health functions.

Erosion of core funding

Support for core public health services began to decline during the 1970s, when the state repealed dedicated funding for public health services. (See box, next page.)

Inconsistent levels of investment

One of the most difficult problems in the public health financing realm is the lack of consistency across counties. Washington's 34 independent local boards of health govern local funding decisions, so it is possible for significant reductions to accrue without anyone seeing the whole picture. There is no local minimum level of investment for public health, a situation that leads to great disparities over time. In 2001, county tax support ranged from 94 cents to $26.05 per person per year. While the amount invested locally depends on many factors (overall county revenues, past levels of spending, decisions about fees, participation by cities within a county), the sheer size of this disparity indicates that

"We have worked on achieving stable and sufficient funding of public health in Washington for more than a decade. This effort is more important than ever in the wake of chronic underfunding in recent years."
—Finance Committee Co-chair Tim McDonald (Health Director, Island County Health Department)

The Erosion of Public Health Funding in Washington

1976: The Washington Legislature repeals dedication of a 21-cent local property tax to public health. City and county financing is now subject to local decision-making, and a wide variation in funding and service levels develops in the ensuing years.

1993: Anticipating support from the Motor Vehicle Excise Tax (MVET), cities are released from funding public health, to take effect in 1996.

1996: The MVET for public health takes effect, but this source provides $7 million less in funding than would city contributions. Health departments are held to historical local funding amounts, so a wide variation in support is sustained.

2000: MVET funding is repealed, just as this revenue source—through inflation growth—approaches the 1995 funding levels.

2001: The Legislature restores or "backfills" MVET, but at 90%, so resources drop by more than $2.5 million a year.

2002: MVET for public health is scheduled to be dropped from budgets beginning July 1, 2003. This would leave a $26 million shortfall for local health departments, a single reduction of 8% in a year when many other funding reductions are anticipated in local, state, and federal programs.

not all Washington residents receive the same level of public health protection.

Categorical constraints

The funding provided from state and federal sources nearly always carries strict categorical restrictions for use in special programs. The spectrum of programs ranges from clean water to HIV/AIDS prevention. Taken alone, each special program seems very important. The problem occurs when many special programs are laid onto an agency already struggling with lack of funding for core services or basic infrastructure. The result is a patchwork of unrelated public health efforts and no flexibility to use resources, in a common-sense way, to fill in the missing pieces at the community level.

One source of state funds, called Local Capacity Development Funding (LCDF), is an exception to the categorical fund problem. The state provided these resources to local public health agencies at the inception of PHIP work in the mid-1990s. Local health officials have continually cited LCDF as their most valued state funds. While the size of the fund is relatively small ($15 million), the agencies have flexibility in their use of the money to meet local needs.

The PHIP Finance Committee has sorted through a complicated array of grants, categorical restrictions, and diverse funding methods that direct resources into state and local public health activities. This work, reported in detail in the 2000 PHIP, revealed where current financing methods had gone awry. The committee also set forth a set of principles to guide an improved system. In the past year, it has focused on identifying funding methods that would balance spending with system accountability, efficiency, and performance.

The Finance Committee's work is challenging some of the basic assumptions about funding the public health system. For example, if funds are reduced, how is the shared state-local responsibility for public health affected? Which basic services should be

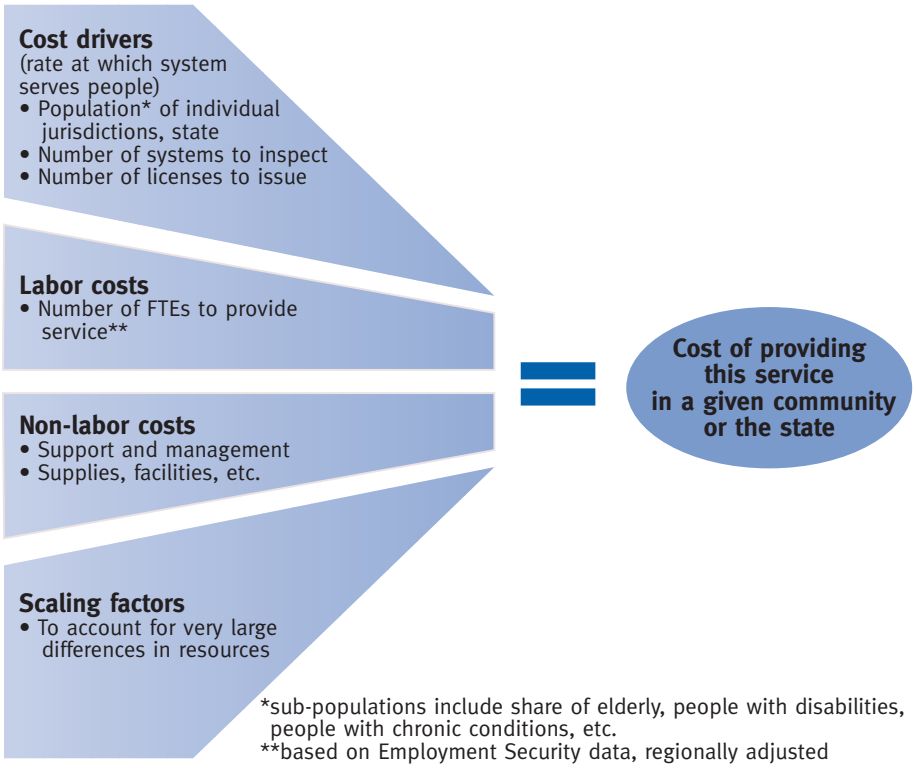
For more information about Financing:

PHIP Public Health Finance Committee Page
http://www.doh.wa.gov/phip/Financing.htm

Institute of Medicine reports:
http://www.nap.edu/books/0309086221/html/

http://www.iom.edu/iom/iomhome.nsf/WFiles/AssuringFINAL/$file/AssuringFINAL.pdf

Calculating the Cost of Providing Public Health Services



The cost model generates calculations that reveal starkly how much public health's declining revenue base has eroded the system's ability to perform public health functions. Statewide, the public health system's $507 million annual expenditure for basic services amounts to only about a third of what the services list and cost model predict the state should be spending.

The committee's future work will be to refine and scale the cost model so that it works well for statewide services and for all health jurisdictions, regardless of size. It will also spell out opportunities for efficiency and joint ventures among partners in the system. And the committee will look for ways to achieve economies of scale that could be brought about through such partnerships.

maintained? Which categorical services should be reduced or eliminated? Can services be both locally responsive and cost-effective? What can be done to address the disparity among local areas in the level of public health services?

To begin to answer these questions, the committee created a detailed list of the state and local public health services that should be available in every community in Washington. They used *Standards for Public Health in Washington State* as a guide and included more than 100 activities, ranging from food safety inspections to immunizations, that most people assume to be part of basic public health services. (See Appendix 5.)

To calculate the true cost of performing these services throughout Washington, the committee created a cost model. For each activity, the cost model identifies *cost drivers*, such as population or the number of facilities to inspect, as well as the labor costs (in full-time equivalent employees, or FTEs) necessary to perform the service. The model also accounts for administrative or non-labor costs as well as the impact of very large or very small public health agencies.

To study the effects of categorical funding, the committee examined how allocations are made for more than 60 separate grants, amounting to about 25% of local public health spending. It determined that allocation formulas are often based on outdated data and assumptions and that new allocation mechanisms are needed to distribute funds more effectively and to meet system performance standards.

Currently, many categorical grants have a separate advisory committee and a funding cycle that is not in synch with other grants. Not surprisingly, the result is a sense of confusion and lack of cohesion. To achieve a simple, clear, and understandable method of allocating funds, the committee is examining ways to integrate fund administration for similar programs, streamline procedures for transferring funds, and combine advisory committees to standardize the criteria used to make funding decisions.

Recommendations for 2003-2005

1. Establish a public health financing system that provides stable and sufficient funding allocated consistently throughout the state.

   All residents of Washington State need and expect a predictable level of public health services. Financing for the system must make effective use of state and local resources and must be allocated so that health protection is sustained in all communities.

2. Adopt a cost model for use throughout the state so that the cost of providing public health services is well documented and can be compared with local and state funding levels. Link costs with related activities for public health improvement, including workforce development and performance standards.

   Cost-modeling work must continue so that the cost of public health protection is documented over time. Cost data are essential for accountability and to examine the effects of categorical grants on general public health programs. The cost model must be linked to *Standards for Public Health in Washington State* to reveal areas of weakness that may need greater investment. Over time, the cost model must expand to account for the contributions of other public agencies and community organizations.

3. Implement and expand the concept of consolidated advisory committees to address funding allocations with the goal of simplifying the allocation process and increasing understanding and acceptance of the allocation methodology.

   Standards for Public Health in Washington State provide a framework that can become a basis for organizing information on the use of public health funding statewide. Combining efforts of many independent advisory committees will create a fuller picture of current activities and spending. While balancing federal and state mandates, it may be possible to integrate funding allocations for greater benefit. In addition, review by broad-based committees will make funding decisions clearly visible to all parties.